STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Liceensure Section conducted an annual survey on April 28, 2021 to May 3, 2021 with a telephone exit on May 3, 2021.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 degrees Fahrenheit (F) and 116 degrees F as evidenced by hot water temperatures higher than 116 degrees F for 2 of 2 bathroom sink fixtures. The findings are: Review of the Technical Document from the American Society for Hospital Engineering dated 1982 revealed a water temperature of 124 degrees F may result in a first degree burn in 2 minutes and a second degree burn in 4.2 minutes. Observation of the residents' common hall bathroom on 04/28/21 at 10:29am revealed: -The hot water temperature at the sink was 122	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 105	Continued From page 1	C 105		

degrees Fahrenheit (F).
-No steam was observed.

Observation of the residents' common bathroom beside the kitchen on 04/28/21 at 10:32am revealed:
-The hot water temperature at the sink was 123 degrees F.
-Steam was observed.

A second observation of the common hall bathroom on 04/28/21 at 1:54pm revealed a water temperature at the sink of 120 degrees F.

A second observation of the residents' common bathroom beside the kitchen on 04/28/21 at 1:56pm revealed a water temperature at the sink of 121 degrees F.

A third observation of the common hall bathroom on 04/28/21 at 4:56pm revealed:
-A water temperature at the sink was 120 degrees F.
-A sign had been placed above the sink, "hot water".

A third observation of the residents' common bathroom beside the kitchen on 04/28/21 at 5:00pm revealed:
-A water temperature of 118 degrees F.
-A sign had been placed above the sink, "hot water"

Interview with 3 of 4 residents on 04/28/21 at 10:35am through 10:40am revealed:
-One resident did not know if the water was to hot or not.
-One resident did not require assistance from staff in the bathroom and was able to adjust the water to keep from getting burned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 105	Continued From page 2 -One resident did not require assistance from staff in the bathroom and had not experienced any problems with the water being to hot as she could also adjust the facet. Interview with the Administrator on 04/28/21 at 10:42am revealed: -All residents were assisted to the bathroom for assistance. -She was not aware the hot water in the facility was too hot. -She did not have a water temperature log because she did not check hot water temperatures. -She had the element replaced in the hot water heater in February 2021 which could have accounted for the water temperatures being high. Interview with a medication aide/personal care aide (MA/PCA) on 04/29/21 at 10:28am revealed: -The staff assisted one of the four residents to the bathroom for toileting, bathing, and washing their hands. -Staff adjusted the water temperature for the one resident who required assistance. -She had not noticed any issues with the water temperatures being too hot or too cold because she could adjust the temperature at the fixture. Recheck of the residents' common hall bathroom on 04/29/21 at 9:26am revealed: -The hot water temperature at the sink was 114 degrees F. Recheck of the common bathroom beside the kitchen on 04/29/21 at 9:30am revealed the hot water temperature at the sink was 114 degrees F. _____ Based on observations, record reviews and interviews, the facility failed to ensure hot water	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 105	Continued From page 3 temperatures in the two sinks in the common bathrooms used by 4 of 4 residents were maintained. A water temperature of 124 degrees F may result in a first degree burn in 2 minutes and a second degree burn in 4.2 minutes. This failure was detrimental to the safety and health of these residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/28/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 17, 2021.	C 105		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) had a criminal background completed upon hire. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record on 04/29/21 revealed: -Staff A was hired as a PCA on 05/10/17. -There was documentation of a criminal	C 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 4	C 147		

background check but there was no date listed when it was completed.
-The criminal background documentation showed a disclaimer, "Records can be incomplete or contain inaccuracies" and "False matches are possible, especially for individuals with common names."

Interview with Staff A on 05/03/21 at 10:40am revealed:
-She worked as a medication aide (MA) occasionally in the facility when she was needed.
-She administered medications and provided personal care to the residents.

Interview with the Administrator on 04/29/21 at 12:23pm revealed Staff A did not work in the facility very often.

Refer to the telephone interview with the Administrator on 05/03/21 at 10:50am.

2. Review of Staff B's, personal care aide (PCA), personnel record on 04/29/21 revealed:
-Staff B was hired as a PCA on 01/15/21.
-There was documentation of a criminal background check completed 02/22/21 from an online website.
-The report had a disclaimer that information from collected from consumer reports and should not be used to evaluate an individual for employment.

Observation upon entry to the facility on 04/28/21 at 10:15am revealed Staff B was the only staff present in the facility.

Interview with Staff B on 04/29/21 at 9:25am revealed:
-She had started working in the facility in February 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 5 -She was "learning" how to be a MA. Refer to the telephone interview with the Administrator on 05/03/21 at 10:50am. _____ Telephone interview with the Administrator on 05/03/21 at 10:50am revealed: -She was responsible for completing the criminal background checks before someone started working at the facility. -The local court had been closed and she did not think she could get the local criminal background check completed. -She had completed the criminal background check through an online company. -She did not know this would not count as an approved criminal background check for employment.	C 147		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 171	Continued From page 6	C 171		

facility failed to ensure 1 of 3 sampled staff (Staff B) had completed competency validation for licensed health professional support (LHPS) task related to administering medication by injection and checking finger stick blood sugar.

The findings are:

Review of Staff B's, personal care aide (PCA), personnel record on 04/29/21 revealed:
-Staff B was hired as a PCA on 01/15/21.
-There was no documentation of a completed competency validation for LHPS tasks.

Interview with a resident on 04/29/21 at 10:41am revealed:
-Staff B administered insulin to her in the last few weeks.
-She could not remember the last time Staff B administered her insulin.
-Staff B also checked her "blood sugar."

Interview with Staff B on 04/29/21 at 9:25am revealed she had not administered insulin to Resident #1 because she was "learning" to administer medications to the residents.

Interview with the consultant registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 11:50am revealed:
-He was responsible for checking off on the staff LHPS competency validation checklist.
-The Administrator had to call and notify him if a staff needed the checklist completed.
-He was available "upon request."
-He had not completed a LHPS competency validation checklist for a staff member of the facility in the last year.

Interview with the Administrator on 04/29/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 171	Continued From page 7 10:03am revealed: -The PCA had started working in the facility mid-February. -The PCA did laundry, cooking, and sometimes provided personal care. -She was just a "sitter" for the facility while she was learning to administer medications. -She had watched Staff B administer insulin to a resident because she was preparing Staff B for her MA training class. -Staff B had not completed any training since she started working at the facility, including a LHPS competency validation.	C 171		
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times; and (g) sliding scale insulin administration.	C 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	Continued From page 8 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had completed training on the care of diabetic residents prior to the administration of insulin. The findings are: Review of Staff B's, personal care aide (PCA), personnel record on 04/29/21 revealed: -Staff B was hired as a PCA on 01/15/21. -There was no documentation of a completed the medication administration competency validation skills checklist. -There was no documentation of training on the care of diabetic residents. Review of a resident's March 2021 electronic Medication Administration Record (eMAR) revealed Staff B documented medications were administered to the resident, including Novolog (used to treat diabetes) Kwikpen. Interview with a resident on 04/29/21 at 10:41am revealed: -Staff B administered insulin to her in the last few weeks. -She could not remember the last time Staff B had administered her insulin. -Staff B also checked her "blood sugar." Interview with Staff B on 04/29/21 at 10:28am revealed she had not completed any training on diabetic care. Interview with the consultant registered nurse (RN) from the facility's contracted pharmacy on	C 174		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 174	Continued From page 9 04/29/21 at 11:50am revealed: -He provided diabetic training to the facility. -The Administrator was responsible for notifying him if the facility had a MA that needed to complete the training. -The Administrator had not contacted him to schedule diabetic training. Interview with the Administrator on 04/29/21 at 12:23pm revealed: -Staff B had not administered any insulin or other medications to the resident. -She was training Staff B to become a MA. -She "clicked" Staff B's name on the eMAR if Staff B was watching her administer the medications. -She had observed Staff B administering insulin to a resident. -She allowed Staff B to administer insulin to a resident to let her prepare for her MA training class.	C 174		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 10 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #2) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #2's current FL2 dated 09/25/20 revealed diagnoses included diabetes, dementia, polyneuropathy due to diabetes, hypomagnesemia, osteoporosis, anxiety, diverticulitis of the colon and pulmonary embolism. Review of Resident #2's Resident Register revealed an admission date on 10/16/19. Review of Resident #2's immunization record revealed: -There was documentation of a TB screening form dated 10/14/19 completed by the local health department.. -There was no documentation of a TB skin test completed upon admission to the facility. Interview with the Administrator on 04/29/21 at 10:45am revealed: -Resident #2 had been screened at the local health department for TB prior to her admission. -There was a shortage of TB serum at the time Resident #2 was admitted, so a TB screening was completed. -She was aware residents had to have 2 completed TB skin tests upon admission to the facility. -She was responsible for making sure residents	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 11 TB skin tests were completed upon admission. -The nurse that came from the facility contracted pharmacy administered all her TB skin shots and he came quarterly to the facility. Interview with the registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 12:10pm revealed: -He assisted in administering TB skin shots for the facility's residents as needed. -The Administrator would notify him if he needed to administer a TB skin shot. -He had not been asked to administer a TB skin test for Resident #2. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	C 202		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 3 sampled residents (Resident #1) related to a gynecological and a pulmonology referral and the refusal of medications for fluid control and a potassium supplement. The findings are:	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 12	C 246		

Review of Resident #1's current FL2 dated 11/14/2020 revealed diagnoses included diabetes, anxiety, depression, chronic obstructive pulmonary disease (COPD) and hypothyroidism.

a. Review of Resident #1's Progress Notes from the primary care provider (PCP) dated 04/22/21 revealed a physician's order for a follow-up visit with Resident #1's gynecologist as soon as possible for abnormal uterine bleeding.

Interview with Resident #1 on 04/29/21 at 12:35pm revealed:
-She was having some bleeding and needed "surgery."
-Her bleeding was about the same as it had been but had not stopped.
-She was waiting on the "Women's Clinic" to call and schedule an appointment for a follow up visit.
-She had to have a pulmonology visit before she could be cleared for the surgery.

Telephone interview with a nurse from the gynecologist's office on 04/29/21 at 11:13am revealed:
-It was important for Resident #1 to get a follow-up for her abnormal uterine bleeding.
-The gynecologist had requested a pulmonology and cardiology referral before completing a procedure to evaluate the cause of the uterine bleeding.
-There was a canceled appointment on 04/13/21 for Resident #1.
-She did not know if Resident #1 or the facility had canceled the appointment.
-The Administrator told her over the telephone on 04/28/21 that Resident #1's bleeding had stopped, and she was questioning if she needed the procedure.
-She was at an increased risk for bleeding, risk of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 13 fall due to blood loss, -Uterine bleeding after menopause was a sign of cancer and if Resident #1 was not properly monitored then it could be life threatening. Telephone interview with a nurse from Resident #1's PCP office on 04/30/21 at 1:43pm revealed: -Resident #1 needed a follow up appointment with the gynecologist within 2 to 3 weeks. -Resident #1 should not wait until all referrals were completed before having a follow-up visit with the gynecologist. -Resident #1 was at an increased for hemorrhage, anemia, and infection. -Resident #1 was at risk of delaying the treatment of a serious underlying condition such as cancer because she was not being monitored. Interview with the Administrator on 04/29/21 at 1:31pm revealed: -She knew Resident #1 needed a follow up visit with her gynecologist. -She was responsible for making provider appointments for all the residents. -She went with Resident #1 to her appointment with her PCP on 04/22/21 when he made the referral to get a follow up with gynecology as soon as possible. -She was going to wait to make the appointment with gynecology until the pulmonology referral was completed. -She did not think Resident #1 was having any trouble with bleeding and may not need the surgery anymore. -She did not think Resident #1 needed to go back to the gynecologist until all the referrals were completed. -The gynecologist needed the referral information before he could complete the surgery.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 14 b. Review of Resident #1's Record revealed a signed physician's order dated 12/29/20 for a pulmonologist referral. Interview with Resident #1 on 04/29/21 at 12:35pm revealed: -She wanted to get an appointment with a pulmonologist that was closer to the facility. -She did not like having to go "so far" for an appointment. -She was waiting for the Administrator to schedule the pulmonology appointment because she needed surgery. Telephone interview with the medical assistant from the pulmonologist's office on 04/29/21 at 1:00pm revealed she did not see any current appointments scheduled for Resident #1. Telephone interview with a registered nurse from Resident #1's PCP office on 04/30/21 at 1:43pm revealed: -Usually it was expected for a referral to take 2 to 3 months to complete. -The referral service for the office usually had appointments set up in about 5 days. -If the patient had not heard from the office where they were referred after 5 days then they should call the office of the referred provider. -Resident #1 should have been evaluated by a pulmonologist by now. Telephone interview with the registered nurse from Resident #1's gynecologist's office on 04/29/21 at 11:13am revealed: -Resident #1 needed a referral to the pulmonologist because she had a history of pleural effusions. -The gynecologist wanted to have the results from the pulmonology referral to assess if	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 15 Resident #1 would have breathing issues during surgery. Interview with the Administrator on 04/28/21 at 12:50pm revealed: -Resident #1 had a referral to visit a pulmonologist because she needed clearance for surgery at the "Women's Clinic." -She felt like Resident #1 was not going to be cleared for surgery because of some recent results on two tests ordered by the cardiologist so she was not sure she was going to make another appointment with the pulmonologist. -She was responsible for making appointment for all the residents. -Resident #1 had an appointment on 01/18/21 with a pulmonologist that had an office close by, but she had to cancel because of bad weather. -The pulmonologist's office had also canceled an appointment that was scheduled for Resident #1. -She did not have a way of transporting Resident #1 to a pulmonologist that was further away from the facility. c. Review of Resident #1's Physician Order Sheet dated 02/18/21 revealed a physician's order for furosemide (used to treat excess fluid) 20mg take 1 tablet twice daily. Review of Resident #1's record revealed a physician's order dated 04/06/21 for furosemide (used to treat excess fluid) 20mg take 1 tablet by mouth every morning. Review of Resident #1's April 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for furosemide 20mg take 1 tablet twice daily scheduled to be administered at 8:00am and	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 16	C 246		

8:00pm.
-Furosemide 20mg take 1 tablet twice daily was documented as administered twice daily at 8:00am and 8:00pm from 04/01/21 to 04/06/21.
-There was a computer-generated entry for furosemide 20mg take 1 tablet once daily scheduled to be administered at 8:00am.
-Furosemide 20mg was not documented administered for 16 out of 22 opportunities from 04/07/21 to 04/28/21 because the resident refused the potassium.

Interview with Resident #1 on 04/28/21 at 12:45am revealed:
-She had refused furosemide because she did not like getting up multiple times a night to go to the bathroom.
-She was taking a lot of medications and did not think it would hurt her to miss two of them.

Interview with the Nurse Practitioner (NP) from the local palliative care office on 04/28/21 at 2:08pm revealed:
-She did not know Resident #1 was refusing the furosemide.
-She had switched the furosemide to once daily dosing at the beginning of April because the resident was concerned with waking up at night and having to go to the bathroom.
-She thought only administering the medications in the morning would help the resident.

Telephone interview with a registered nurse from Resident #1's primary care provider's (PCP) office on 04/30/21 at 1:43pm revealed:
-She did not see any documentation that facility staff had called to let them know Resident #1 was refusing her furosemide.
-Resident #1 was at an increased risk of worsening edema and congestive heart failure if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 17	C 246		

she did not take the furosemide.
-It was important for Resident #1 to take the furosemide as prescribed by the PCP.

Interview with the Administrator on 04/28/21 at 12:50pm revealed:
-Resident #1's PCP knew that Resident #1 was refusing furosemide.
-She had called and reported the refusals to the PCP but she did not document the information.

Interview with the Administrator on 04/28/21 at 1:43pm revealed:
-She was trying to get the PCA to encourage Resident #1 to take all her medications.
-Resident #1's PCP knew she was refusing the furosemide.
-She left a message for the PCP "last week" and he had his nurse call back saying to continue to administer the furosemide to Resident #1.

Interview with the Administrator on 04/28/21 at 4:37pm revealed:
-The facility policy was to call the provider after three consecutive medication refusals.
-She was responsible for contacting the provider if a resident refused their medications.
-She had no documentation that she had contacted Resident #1's PCP about medication refusals.

d. Review of Resident #1's Physician Order Sheet dated 02/18/21 revealed a physician's order for potassium (used as a supplement to treat low potassium levels) 8mEq take 1 tablet twice daily.

Review of Resident #1's record revealed a physician's order dated 04/06/21 for potassium ER 8mEq take 1 tablet by mouth daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 18 Review of Resident #1's April 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for potassium 8mEq take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm. -Potassium 8mEq take 1 tablet twice daily was documented as administered twice daily at 8:00am and 8:00pm from 04/01/21 to 04/06/21. -There was a computer-generated entry for potassium 8mEq take 1 tablet once daily scheduled to be administered at 8:00am. -Potassium 8mEq was not documented as administered for 16 out of 22 opportunities from 04/07/21 to 04/28/21 because the resident refused the potassium. Interview with Resident #1 on 04/28/21 at 12:45am revealed: -She refused the potassium because she had refused the furosemide. -She did not think she needed the potassium if she was going to refuse the furosemide. -She was taking a lot of medications and did not think it would hurt her to miss two of them. Interview with the Nurse Practitioner (NP) from the local palliative care office on 04/28/21 at 2:08pm revealed: -She did not know Resident #1 was refusing potassium. -She had switched the potassium to once daily dosing at the beginning of April because the resident was concerned with waking up at night and having to go to the bathroom. -She thought only administering the medications in the morning would help the resident. Telephone interview with a nurse from Resident	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 19	C 246		

#1's primary care provider's (PCP) office on 04/30/21 at 1:43pm revealed:
-She did not see any documentation facility staff had called to let them know Resident #1 was refusing her potassium.
-The resident was at an increased risk of hypokalemia (low potassium level in blood serum) if she did not take her potassium.
-Hypokalemia was the result of not having enough potassium and it could lead to problems with the heart.
-It was important for Resident #1 to take the potassium as prescribed by the PCP.

Interview with the Administrator on 04/28/21 at 12:50pm revealed:
-Resident #1's primary care provider (PCP) knew that Resident #1 was refusing potassium.
-She had called and reported the refusals to the PCP but she did not document the information.

Interview with the Administrator on 04/28/21 at 1:43pm revealed:
-She was trying to get the PCA to encourage Resident #1 to take all her medications.
-Resident #1's PCP knew she was refusing the potassium.
-She left a message for the PCP and he had his nurse call back saying to continue to administer potassium to Resident #1.

Interview with the Administrator on 04/28/21 at 4:37pm revealed:
-The facility policy was to call the provider after three consecutive medication refusals.
-She was responsible for contacting the provider if a resident refused their medications.
-She had no documentation that she had contacted Resident #1's PCP about medication refusals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 20 The facility failed to ensure referral and follow-up for a gynecology referral for Resident #1 with abnormal uterine bleeding which put the resident at an increased risk of bleeding, anemia, infection, falls due to loss of blood, and potentially delayed treatment for a serious underlying cause such as cancer; facility failed to notify Resident #1's primary care provider regarding medication refusals for furosemide and potassium which increased the risk of excess fluid leading to congestive heart failure. This failure placed Resident #1 at substantial risk for physical harm and neglect and constitutes a Type A2 violation. The facility provided a Plan of Protection on in accordance with G.S. 131D-34 on 04/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 2, 2021.	C 246		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure all food items stored by the facility were protected from contamination related to unlabeled and undated food in the kitchen	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 257	Continued From page 21 refrigerator and 2 of 2 freezers. The findings are: Observation of the refrigerator and side freezer in the kitchen on 04/28/21 at 11:15am revealed: -There was 9 x 13 casserole dish, half full with orange jello with no cover, dated or labeled. -There was a gallon Ziploc bag almost full with chopped lettuce that had been opened, not dated or labeled. -There was a gallon Ziploc bag 1/4 full with carrots that had been opened, not dated or labeled. -There was a two inch section of a roll of hamburger meat in a Ziploc bag that ad been opened,was not dated or labeled. -There was a gallon Ziploc bag containing 1/4 of a head of cabbage, with brown spots, had been opened, not dated or labeled. -There was a small bag with 3 fish sticks that had been opened and approximately 1/2 cup of freezer ice twisted closed not dated or labeled. Observation of the top freezer in the outside utility room on 04/28/21 at 11:20am revealed: -There were 2 gallon freezer bags of sliced squash not dated or labeled. -There were approximately 9 Ziploc bags of chicken parts not dated or labeled. -There were two, 1 pound (lb.) unopened bags of venison burger not dated. -There appeared to be an opened, half portion of a turkey breast in a gallon freezer bag, freezer burnt with about a cup of freezer ice in the bag covering the meat not dated or labeled. -There was an unopened beef roast in a clear bag, green in color on one side with freezer ice in the bag not dated or labeled.. -There was a Ziploc bag of opened, unidentified	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 257	Continued From page 22 meat, freezer burnt with freezer ice covering the meat not dated or labeled.. -There were two, opened, zip locked bags of hamburger, freezer burnt not dated or labeled. Interview with the Administrator on 04/28/21 at 11:20am revealed: -She was the one who was responsible for labeling and dating the grocery items. -She had not dated and labeled any of the opened or repackaged food items. -She ordered the food items once a month and knew everything in the refrigerator and freezers were all fresh. -She could not recall the last time the freezer was cleaned.	C 257		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 23 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure documentation on the electronic Medication Administration Record (eMAR) was accurate and contained the name or initials of the person administering the medication for 1 of 3 sampled resident (Resident #2) with an order for a anxiety medication. The findings are: Review of Resident #2's current FL2 dated 09/25/20 revealed: -Diagnoses included dementia, anxiety, diabetes, polyneuropathy related to diabetes, diverticulitis and osteoporosis. Review of a physician's order for Resident #2 dated 10/28/20 for an order for lorazepam 0.5mg every 8 hours as needed for anxiety. Review of the electronic medication record administration (eMAR) for March 2021 for Resident #2 revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety. -There was documentation of administration on 03/04/21,- 03/08/21, 03/11/21, 03/12/21, 03/15/21, 03/17/21- 03/20/21, 03/23/21 and 03/26/21. -There was documentation of administration twice on 03/09/21 and 03/21/21. -There was documentation of administration four times on 03/10/21.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 24 -There was no time of administration documented for the lorazepam 0.5mg. Review of the eMAR for April 2021 for Resident #2 revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety. -There was documentation of administration on 04/01/21, 04/08/21, 04/09/21 and 04/21/21. -There was documentation of administration three times on 04/17/21. -There was no time of administration documented for the lorazepam 0.5mg. Review of the Resident #2's controlled substance count sheets (CSCS) compared to the eMAR revealed: -There was a CSCS for lorazepam 0.5mg every 8 hours as needed for anxiety with a dispense date of 10/26/20 for a quantity of 90 tablets. -There were 3 of the lorazepam 0.5mg were documented as signed out for two times on 02/24/21 and 03/20/21. -The last entry on the CSCS documented 86 tablets remained. -There was another CSCS for lorazepam 0.5mg with a dispense date of 09/28/20 for a quantity of 90 pills. - There were 82 lorazepam 0.5mg tablets documented as administered. -The last entry on the CSCS documented 1 tablet remained. Observation of Resident #2's medications on hand for administration on pm revealed: -There were 85 lorazepam 0.5mg in a bubblepack with a dispense date of 10/26/20. -There were 1 lorazepam 0.5mg in a bubblepack with a dispense date of 09/28/20.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 25 Interview with the pharmacist for the facility's contracted pharmacy on 04/29/21 at 9:14pm revealed: -There was an order for lorazepam 0.5mg every 8 hours as needed for anxiety on 09/28/20 with 5 refills. -The lorazepam 0.5mg was filled on 09/28/20, 10/26/20, 03/22/21 with 90 tablets being dispensed each time. -There had been no refill request between 10/26/20 and 03/22/21. -The facility was responsible for requesting the refills as they were not an automatic refill. Interview with a personal care aide (PCA) on 04/29/21 at 10:28am revealed: -She was being trained by the Administrator to administer medications and she had administered medications to Resident #2. -She had been trained to sign the CSCS first by the number on the bubblepack, remove the medication from the bubblepack, administer the medication to Resident #2 and then document on the eMAR the medication had been given. -She was not sure why the documentation was incorrect as she was still learning. Interview with the Administrator on 04/29/21 At 10:45pm revealed: -The eMAR should match the CSCS as to what was administered. -She could not explain why the eMAR was inaccurate. -She thought the CSCS was more accurate than the eMAR as that was what she had taken out of the bubblepack.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 26 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the record of controlled substances was maintained and reconciled accurately for 2 of 2 sampled residents with an order for a anxiety medication (Resident #2) and a pain medication (Resident #1). The findings are: 1. Review of Resident #2's current FL2 dated 09/25/20 revealed diagnoses included dementia, anxiety, diabetes, polyneuropathy related to diabetes, diverticulitis and osteoporosis. Review of a physician's order for Resident #2 dated 10/28/20 revealed an order for lorazepam 0.5mg every 8 hours as needed for anxiety. Review of the electronic medication record administration (eMAR) for March 2021 for Resident #2 revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety. -There was documentation of administration on 03/04/21,- 03/08/21, 03/11/21, 03/12/21, 03/15/21, 03/17/21- 03/20/21, 03/23/21 and 03/26/21. -There was documentation of administration twice on 03/09/21 and 03/21/21.	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 27 -There was documentation of administration four times on 03/10/21. -There was no time of administration documented for the lorazepam 0.5mg. Review of the eMAR for April 2021 for Resident #2 revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety. -There was documentation of administration on 04/01/21, 04/08/21, 04/09/21 and 04/21/21. -There was documentation of administration three times on 04/17/21. -There was no time of administration documented for the lorazepam o.5mg. Review of the Resident #2's controlled substance count sheets (CSCS) revealed: -There was a CSCS for lorazepam 0.5mg every 8 hours as needed for anxiety with a dispense date of 10/26/20 for a quantity of 90 tablets. -There were 3 lorazepam 0.5mg tablets documented as signed out two times on 02/24/21 and 03/20/21. -The last entry on the CSCS documented 86 tablets were available. -There was another CSCS for lorazepam 0.5mg with a dispensed date of 09/28/20 for a quantity of 90 pills. - There were 82 lorazepam 0.5mg tablets were documented as signed out. -The last entry on the CSCS documented 1 tablet remaining. Observation of Resident #2's medications on hand for administration on 04/28/21 at 2:14pm revealed: -There were 85 lorazepam 0.5mg in a bubble pack with a dispense date of 10/26/20. -There was 1 lorazepam 0.5mg tablet in a bubble	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 28 pack with a dispense date of 09/28/20. Interview with the Administrator on 04/29/21 at 10:45am revealed she had added the count number of the Lorazepam with other staff on the CSCS so that could have been why the count was inaccurate. Refer to interview with the Administrator on 04/29/21 at 10:45am. 2. Review of Resident #1's current FL2 dated 11/14/2020 revealed diagnoses included diabetes, anxiety, depression, chronic obstructive pulmonary disease (COPD) and hypothyroidism. Review of a physician's order for Resident #1 dated 02/10/21 revealed a signed physician's order for tramadol (used to treat mild to moderate pain) 50mg take 1 tablet every 6 hours as needed. Review of a physician's order for Resident #1 dated 04/02/21 revealed a signed physician's order for tramadol 50mg take 1 tablet three times daily. Review of Resident #1's April 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for tramadol 50mg take 1 tablet three times daily scheduled to be administered at 8:00am, 2:00pm, and 8:00pm. -Tramadol 50mg was documented as administered three times daily at 8:00am, 2:00pm, and 8:00pm from 04/02/21 to 04/28/21. -There was a computer-generated entry for tramadol 50mg take 1 tablet every six hours as needed.	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 29	C 367		

-There was 1 dose of tramadol documented as administered on 04/09/21 as an as needed administration.
-There was a total of 83 tablets of tramadol 50mg documented as administered from 04/01/21 to 04/28/21.

Review of Resident #1's April 2021 controlled substance count sheets (CSCS) revealed:
-There was a CSCS for tramadol 50mg take 1 tablet three times daily with a dispensed date of 04/02/21 for a quantity of 21 tablets.
-The first dose of tramadol was recorded as signed out on 04/06/21 at 2:51am with 21 tablets remaining.
-There were 19 tablets documented as signed out on the CSCS.
-The last entry on the CSCS documented 1 tablet was remaining.
-There was another CSCS for tramadol 50mg take 1 tablet three times daily with a dispense date of 04/08/21 for a quantity of 69 tablets.
-The first dose of tramadol was recorded as administered on 04/13/21 at 8:00am with 68 tablets remaining.
-There were 45 tablets documented as administered on the CSCS from 04/06/21 to 04/28/21.
-The last entry on the CSCS documented 24 tablets were available to administer.
-There was no CSCS available showing the inventory of tramadol 50mg tables from 04/01/21 to 04/05/21.

Observation of Resident #1's medications on hand on 04/28/21 at 1:45pm revealed there were 24 tramadol 50mg tablets in a bubble pack with a dispense date of 04/08/21.

Interview with the Administrator on 04/28/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 30 1:31pm revealed: -She did not know why the as needed dose of tramadol was not documented on the eMAR. -All doses of tramadol that were removed from the inventory should be documented on the CSCS. Refer to interview with the Administrator on 04/29/21 at 10:45am. _____ Interview with the Administrator on 04/29/21 at 10:45am revealed: -She was responsible for making sure the CSCS for each controlled medication was accurate. -She had documented the number on the bubble pack by the tablet she removed and placed it on the CSCS not the actual number remaining. -She and her staff were not completing the CSCS properly, but her staff were completing the form incorrectly, so she had tried to make the CSCS easier to understand. -When she completed the CSCS the way she did the count always showed one more pill than was available. -She thought the CSCS was more accurate than the electronic medication administration record as that was what she had taken out of the bubble pack.	C 367		
C 601	10A NCAC 13G .1701 (a) (b) Infection Prevention & Control Program (emer) 10A NCAC 13G .1701 Infection Prevention and Control Program (a) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the	C 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 601	Continued From page 31 federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS), and the facility's infection control policy were implemented and maintained during the global coronavirus (COVID-19) pandemic to provide protection to the residents and to reduce the risk of transmission and infection as related to the staff and residents wearing facemasks and the screening of visitors entering the facility. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility last updated 11/20/20 revealed: -Staff should wear a facemask at all times while they are in the facility. -Residents should wear a cloth face covering or facemask anytime they leave their rooms. -Appropriate personal protective equipment (PPE) should be used by personnel when in contact with the resident. -All visitors to the facility should be screened for	C 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 601	Continued From page 32	C 601		

signs and symptoms of COVID-19 prior to the entering the facility.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed:
-Facility staff should wear appropriate PPE when caring for patients with undiagnosed respiratory infection or confirmed COVID-19.
-Facility staff should wear all recommended PPE, including a surgical mask or N95 mask, gown, gloves and face shield when caring for all residents whether they have tested positive for COVID-19 or not.
-All visitors should be screened for signs and symptoms of COVID-19 prior to entering the facility.

Review of the facility's Infection Control Policy revealed:
-Staff and residents are required to wear facemasks as a barrier to help prevent respiratory droplets from traveling in the air.
-All visitors will enter through the main door.
-All visitors will be screened for the presence of fever and symptoms consistent with COVID-19.

Observation upon entrance to the facility on 04/28/21 at 10:15am revealed:
-The personal care aide (PCA) was not wearing a mask when she opened the door to greet the surveyors.
-The PCA did not offer or request to check the surveyors temperatures or ask any screening questions upon entry.
-There was no screening log visible upon entry into the facility.

Interview with the PCA on 04/28/21 at 10:20am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 601	Continued From page 33	C 601		

revealed:
-The Administrator told her to stop screening visitors coming into the facility but did not tell her why.
-The Administrator told her to stop screening visitors after the residents received their COVID-19 vaccine.
-She had been checking temperatures on all visitors until everyone in the facility had their vaccine.
-Visitors were coming into the facility but had to wear a mask.
-The staff or residents did not wear masks inside the facility, but the residents had masks available if they went into the community.

Observation of the Administrator on 04/28/21 at 10:35am revealed she entered the facility through the side door into the kitchen and was not wearing a mask.

Observation of a Nurse Practitioner (NP) from the local palliative services on 04/28/21 at 1:20pm revealed the facility staff did not screen the NP for signs and symptoms of COVID-19 or did not complete a temperature check.

Interview with the Nurse Practitioner (NP) from the local palliative care office on 04/28/21 at 2:08pm revealed:
-She was screened when she entered the facility "sometimes."
-She checked her temperature in the car before she entered the facility.
-The facility should screen all visitors that entered the facility for signs and symptoms of COVID-19.

Observation of the registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 11:50am revealed he was not screened for signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 601	Continued From page 34 and symptoms of COVID-19 when he entered the facility. Interview with the RN from the facility's contracted pharmacy on 04/29/21 at 1:15pm revealed: -He was not screened for COVID-19 when he entered the facility today (04/29/21). -He could not remember if he was screened when he came to the facility in February 2021. -The facility should be following state guidelines related to screening visitors entering the facility. Interview with the Administrator on 04/28/21 at 10:35am revealed: -The PCA was supposed to screen all visitors with a screening questionnaire and temperature checks prior to anyone entering the facility. -The facility had recently started letting visitors in the facility. -She did not know why the PCA did not screen the surveyors. -She thought "state workers" were exempt from all screening guidelines. -She could not find the visitor logs but was going to keep looking. Interview with the Administrator on 04/28/21 at 2:01pm revealed: -Residents did not wear masks in the facility because they had their second vaccine dose on 04/20/21. -She did not wear a mask because she received one dose of the COVID-19 vaccine. -The residents had masks available to wear if they went out in the community. -It was hard to get the residents to wear a mask inside the facility.	C 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 35	C 912		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure each resident received the care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to building service equipment and health care. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 degrees Fahrenheit (F) and 116 degrees F as evidenced by hot water temperatures higher than 116 degrees F for 2 of 2 fixtures. [Refer to Tag 0105 10A NCAC 13G .0317 Building and Service Equipment (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs of 1 of 3 sampled residents (Resident #1) related to a gynecological and a pulmonology referral and the refusal of medications for fluid control and a potassium supplement [Refer to Tag 0246 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)].	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 932	Continued From page 36	C 932		
C 932	G.S. 131D 4.4A (b) ACH Infection Prevention Requirements 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV,	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 932	Continued From page 37 hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and B) had completed the annual state mandated infection control training. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record on 04/29/21 revealed: -Staff B was hired as a PCA on 05/10/17. -There was documentation of annual state mandated training for infection controlled dated 05/18/17 and 12/13/18. -There was no documentation of annual state mandated training for infection control after 12/13/18. Interview with Staff A on 05/03/21 at 10:40am revealed: -She worked as a medication aide (MA) occasionally in the facility when she was needed. -She did not remember completing any infection control training at the facility. -She had completed infection control training at the previous facility she worked at in February 2020. Refer to the interview with the registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 11:50am. Refer to the telephone interview with the Administrator on 05/03/21 at 10:50am. 2. Review of Staff B's, personal care aide (PC), personnel record on 04/29/21 revealed:	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 932	Continued From page 38 -Staff B was hired as a PCA on 01/15/21. -There was no documentation of annual state mandated infection control training. Interview with Staff B on 04/29/21 at 10:28am revealed she had not received any training on infection control at the facility. Refer to interview with the registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 11:50am. Refer to telephone interview with the Administrator on 05/03/21 at 10:50am. _____ Interview with the registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 11:50am revealed: -He provided the state mandated infection control training to the facility annually. -The Administrator was responsible for notifying him if the facility had staff who needed to complete the training -The Administrator had not contacted him in the last year to provide infection control training to any of the staff at the facility. Telephone interview with the Administrator on 05/03/21 at 10:50am revealed: -She had not provided infection control training to any of the staff in the last year. -She knew she was "behind on infection control." -The facility was not allowing visitors to the facility and she felt like the training was not needed. -She had reviewed with the staff how to put on personal protective equipment (PPE) and how to take it off. -She was responsible for making sure all staff had completed the required training. -She was responsible for calling the Nurse	C 932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 932	Continued From page 39 Consultant and scheduling the infection control training.	C 932		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C935	Continued From page 40 applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications to residents had completed the medication administration competency validated clinical skills checklist, the 5, 10, or 15-hour state approved medication administration training course, and successfully passed the written medication aide examination as required. The findings are: Review of Staff B's, personal care aide (PCA), personnel record on 04/29/21 revealed: -Staff B was hired as a PCA on 01/15/21. -There was no documentation Staff B had completed the 5, 10, or 15-hour state approved medication administration training course. -There was no documentation Staff B had completed the medication administration competency validated medication clinical skills checklist. -There was no documentation Staff B had successfully passed the written medication aide (MA) exam. Review of a resident's March 2021 electronic Medication Administration Record (eMAR) revealed Staff B had documented medications were administered to the resident for 22 of 31 days.	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C935	Continued From page 41 Interview with a resident on 04/29/21 at 10:41am revealed: -Staff B had administered medications to her recently, including insulin. -The Administrator and Staff B had administered her medications. -She did not think Staff B was suppose to be administering the medications. Interview with a second resident on 04/28/21 at 9:59am revealed: -There had been two other staff who had administered her medications besides the Administrator. -Staff B had administered medications without the Administrator being in the facility. Interview with Staff B on 04/29/21 at 9:25am revealed: -She had never administered medications to residents in the facility. -The Administrator told her to sign off on the eMAR that she had administered medications while she was observing the Administrator administer the medications. -She was "learning" how to be a MA. Second interview with Staff B on 04/29/21 at 10:28am revealed she had been trained to pop the medication from the bubble pack, sign the control sheet, administer the medication, and document if the medication was taken or not on the eMAR. Interview with a registered nurse (RN) from the facility's contracted pharmacy on 04/29/21 at 11:50am revealed: -He provided the 5, 10, and 15-hour medication training and was responsible for completing the	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020016	A. BUILDING: _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELAINE'S CARE # 2	17 MOORE STREET ANDREWS, NC 28901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C935	Continued From page 42	C935		

competency validated medication clinical skills checklist for the MAs.
-The Administrator was responsible for notifying him if the facility had a MA that needed to complete the training.
-He had a training scheduled for several weeks ago and the facility had three MAs scheduled to attend but no one showed up for the training.
-The Administrator had not contacted him to reschedule the MA training.

Interview with the Administrator on 04/29/21 at 12:23pm revealed:
-Staff B was not a MA and had not administered any medications to the residents.
-She was training Staff B to become a MA but she was not administering any medications to the residents.
-She allowed Staff B to hand a cup of pills to a resident to take or pour the pills in a resident's hand but would not let her remove the medications from the bubble packs.
-She "clicked" Staff B's name on the eMAR if Staff B was watching her administer the medications.
-She had allowed Staff B to administer insulin to a resident to let her prepare for her MA training class.
-She was responsible for making sure all staff completed required training.
-She had scheduled training in February or March 2021 but other appointments had conflicted with the training dates.
-She had not rescheduled the training.